

Integrated Care Board

Clinical and Care Professional Committee (CCPC)

Terms of Reference

[XX] March 2025

1. Introduction

- 1.1 The NHS South East London Integrated Care Board (ICB) Clinical and Care Professional Committee (CCPC) [the “committee”] is established as a committee of the ICB Board. The committee has no executive powers other than those specifically delegated in these terms of reference. These terms of reference can only be amended by the ICB Board.
- 1.2 These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the committee under its terms of delegation from the ICB Board.
- 1.3 All members of staff and members of the ICB are directed to co-operate with any requests made by the CCPC.

2. Purpose

- 2.1. It is recognised that ensuring clinical and care professional leadership is integral to the way we work as a system and will require a distributed approach across the health and care partnership.
- 2.2. The committee has responsibility for providing clinical leadership in support of ICB decision making and for convening a broader network of clinical and care leaders to support existing leadership in the system.
- 2.3. The ICB and Integrated Care Partnership have committed to clinical and care professional leadership and alignment with the five ICS clinical and care professional leadership design principles included within national ICS implementation guidance¹:
 1. Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.
 2. Nurture a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

¹ <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf>

3. Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work.
 4. Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders (e.g. managers and other non-clinical professionals in local government and the VCSE sector), and provides training and development opportunities that recognise the different kind of leadership skills required when working effectively across organisational and professional boundaries and at the different levels of the system (particularly at place).
 5. Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function
- 2.4. This committee is designed to operate in a way that interlinks to other key decision-making parts of the ICB and broader system's governance arrangements. The CCPC creates a forum in which decisions with a direct clinical impact can be considered and recommendations made to the ICB; it is additive and complementary - where a single conversation with representatives across the SEL system is required.
 - 2.5. The CCPC will support ICB decision making and enable change through its recommendations and by escalation and influence. It will ensure a multi-professional perspective, establish a more systematic improvement and transformation method linked to population health, and share learning and best practice through ICB and regional channels.
 - 2.6. In addition, the CCPC will provide a senior clinical forum for discussion of clinical matters requiring a system-level decision (e.g., regarding Patient Group Directions). In these cases the CCPC will determine if a formal decision is required by the ICB, or if a decision can be made by the CCPC as a clinical leadership group.
 - 2.7. The CCPC will, together with other relevant ICB committees and groups, undertake the following functions on behalf of the ICB:
 - 2.8. **Learning system** – lead coordination of the ICB's approach to becoming a learning system, including a population health management approach, transformation, improvement, evaluation and other components of learning system culture across the full scope of the ICB's activities. This will support the ICS-wide focus on tackling health inequalities.
 - 2.9. **Health inequalities** – to promote and support clinically-led work to tackle health inequalities in southeast London.
 - 2.10. **System-wide clinical and care strategy** – to review and provide clinical advice and guidance in relation to the development of operational and strategic plans

- 2.11. **Care pathway transformation and innovation** – routine review of new or proposed clinical pathways to understand and advise on clinical impact, workforce implications, key messages and implementation requirements.
- 2.12. **Patient and public engagement** – to support the ICB’s approach to patient and public engagement as part of our People and Communities strategic framework and take assurance on the organisation’s engagement activities and processes from the Engagement Assurance Committee (EAC).
- 2.13. **Sustainability** – to support work which improves the sustainability of clinical and care services across southeast London.
- 2.14. **Continuous improvement and innovation** – to drive forward the improvement and innovation agenda across the partnership, ensuring learnings and good practice are disseminated and embedded and that innovation in other areas are harnessed and enacted in south east London.
- 2.15. **Clinical and care professional development** – together with ICB workforce leaders to lead an on-going development and support offer for clinicians and care professional leaders within the ICS and ensure leaders maximise their impact their respective areas of interest and across the partnership more broadly.
- 2.16. **Establishing a broad-based and multi-disciplinary ICB clinical senate** – with the aim of significantly enhancing the breath of clinical input and expertise in the development of clinical strategy and proposals for clinical transformation.
- 2.17. **General clinical advice and input into other ICB functions** – to receive requests from other key ICB functions where clinical advice and input is required. This will include the below functions as a minimum:
- Workforce resilience linked to the ICB Workforce programme.
 - Quality assurance and safety linked with IBC Quality & Performance Committee, System Quality Group and CNO and CMO membership.
 - Professional leadership support and development linked to the ICB Workforce programme and workforce lead role membership.
 - ICB care pathway and enabler work programmes.
 - Leadership in research and evidence.
 - Care standards as requested by ICB, ICS or regional programmes.

3. Duties

- 3.1. The committee is an integral part of the wider ICB governance arrangements and will maximise its impact by working in close alignment with other parts of the organisation’s governance: key committees, ICB clinical transformation programmes and enabler programmes. The CCPC will operate with the following distinct responsibilities:

- 3.2. To oversee the ICB's approach to becoming a learning system in support of the ICS's focus on tackling health inequalities, including population health management.
- 3.3. To oversee the ICS's approach to patient and public engagement as part of our People and Communities strategic framework. This includes receiving the minutes of the Engagement Assurance Committee with reports by exception.
- 3.4. To provide clinical and care professional input into ICB / ICS programmes and other key functions. This will involve detailed consideration of information on clinical strategy, service and pathway changes and will involve the committee considering impacts and making recommendations to inform the proposed change. The committee may also consider information on risks or issues which have been identified with a potential clinical impact and advise on these accordingly.
- 3.5. To direct cross-system clinical work where there is not a programme established to own that activity.
- 3.6. To offer a review and constructive challenge of clinical proposals or cases for change developed within the ICB or broader ICS partnership, and to provide commentary and, where it supports ICB decision making, recommendations to the ICB regarding the direct clinical impact of proposals, projects and other changes.
- 3.7. Interact with region and other partners outside of the ICS in order to input from a clinical perspective to regional programmes and to understand and adopt learning and innovation from other places.
- 3.8. To convene a broad-based, multi-disciplinary clinical and care professional leaders' forum with broader representation from system clinical and care clinical leadership to engage a broader cohort of clinical leaders on matters related to clinical strategy, transformation and programmes of change.

4. Accountabilities, authority, and delegation

- 4.1. The authority delegated to the committee is set out in the ICB's Scheme of Reservation and Delegation.
- 4.2. The committee will act to agree and report against all duties within its scope as recorded in section 3 (above). It will report on its activities to the ICB Board on a minimum annual basis.
- 4.3. The committee is responsible for overseeing activities related to becoming a learning system, including population health management, and engagement assurance.
- 4.4. The committee will receive the minutes, and reports by exception, from the Engagement Assurance Committee and any sub-committees created.
- 4.5. The committee will be provided with a regular opportunity to hear from representatives of its sub-committees. It will be able to act on recommendations or proposals that arise at its sub-committees in line with the ICB Scheme of Reservation and Delegation.

- 4.6. The committee will, together with the ICB Planning and Finance Committee, operate dual reporting lines from ICB care pathway programme boards and key enabler programme boards and workstreams where appropriate. The CCPC will receive updates on progress from clinical leaders in these programmes and offer its support and clinical input as requested.
- 4.7. The committee may establish a working group or task and finish group to lead work under a defined term of reference/ engagement. The committee must agree by majority on the establishment of any of the groups and formally agree their terms of reference.

5. Membership and attendance

- 5.1. The committee members shall be appointed by the Board in accordance with the ICB Constitution. When determining the membership of the committee, active consideration will be made to equality, diversity and inclusion.
- 5.2. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.
- 5.3. The membership seeks to incorporate a broad clinical representation from across the health and care system in south east London; including representation from acute trusts, community providers, mental health providers, general practice, nursing, the ICB executive leadership team, and social care.
- 5.4. ICS partners must nominate appropriate clinical representatives. Representatives are responsible for discussing papers with relevant colleagues prior to the meeting and must be able to provide input into the discussion. Representative members may change between postholders on a meeting-by-meeting basis to suit the topics being discussed.
- 5.5. The committee will be constituted of the following postholders:
- ICB Medical Director (Co-Chair)
 - ICB Chief Nurse (Co-Chair)
 - ICB Deputy Medical Directors
 - 1 x SEL Director of Public Health or Consultant in Public Health
 - Clinical Representative (MD or CNO, or delegate)
 - Guy's & St. Thomas' NHSFT
 - King's College Hospital NHSFT
 - Lewisham and Greenwich NHS Trust
 - Oxleas NHSFT
 - South London and Maudsley NHSFT
 - Bromley Healthcare
 - 1 x Clinical Lead ICB Primary Care Group
 - ICB Chief Pharmacist

- CCPL lead from each Borough
- Clinical lead for Digital
- SEL ICS Director of Voluntary Sector Collaboration and Partnerships

- 5.6. Committee members will be responsible for ensuring relevant issues or activities within their own organisation are discussed where they are relevant to the work of the committee. Intelligence should be shared with the committee from other discussions held within organisations, partnerships or at a regional level.
- 5.7. It is expected that members can make decisions on behalf of their organisations (up to the limits delegated to them) and do so within any set timeframe, securing sign off and cascade from own organisations where applicable.
- 5.8. In addition to the standing membership, other individuals from across the Integrated Care System may be invited to attend as required. It is anticipated that representation from ICS clinical networks / collaboratives and transformation programmes will be requested by the committee on a regular basis. It will also be ensured that a representative of the ICB Quality Directorate is present, if no attending members fulfil this role.
- 5.9. The committee is permitted with agreement of the chair and a majority of members to formally co-opt additional members and/or other subject matter specialists to broaden the range of input should this be deemed necessary.

6. Chair of meeting

- 6.1. The committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.
- 6.2. The meeting will be co-chaired by the ICB Medical Director and ICB Chief Nurse Officer. These post-holders will chair the meeting in sequence.
- 6.3. At any meeting of the committee, the designated chair for that meeting if present shall preside. If the chair is absent, the co-chair shall preside. If the designated co-chair is temporarily absent on the grounds of conflict of interest, the other co-chair shall preside.

7. Quorum and conflict of interest

- 7.1. The quorum of the committee is at least 50% of members of which the following must be present:
 - a. The ICB Medical Director or ICB Chief Nurse
 - b. 3 x representatives of partner organisations
 - c. 3 x CCPL Borough representatives
- 7.2. The committee will operate with reference to NHS England guidance and national policy requirements and will abide by the ICS's standards of business conduct. Compliance will be overseen by the chair of the committee.
- 7.3. The committee agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).
- 7.4. Committee members will be required to declare any interests they may have in accordance with the ICB's Conflict of Interest Policy (included within the Standards of Business Conduct Policy). Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

4. Decision-making

- 7.5. Where a decision is required, it is expected that this will be reached by consensus. Where a vote is required to decide a matter, each member may cast a single vote. In the event of equal votes, the chair will have a casting vote.

8. Procedure of decisions made outside of formal meetings

- 8.1. The committee chair will arrange for the notice of the business to be determined and any supporting paper to be sent to members by email. The email will ask for a response to be sent to the committee chair by a stated date. A decision made in this way will only be valid if the same minimum quorum described in the above paragraph, expressed by email or signed written communication, by the stated date for response, states that they are in favour.
- 8.2. The ICB's governance team will retain all correspondence pertaining to such a decision for audit purposes and report decisions so made to the next meeting. A clear summary of the issue and decision agreed will then be recorded in the minutes of this meeting.

9. Frequency

- 9.1. The committee will meet every three months

- 9.2. All members will be expected to attend all meetings or to provide their apologies, or an alternative representative where appropriate, in advance should they be unable to attend.
- 9.3. Members are responsible for identifying a suitable deputy should they be unable to attend a committee meeting which needs to be agreed with the chair and notified in advance.
- 9.4. Nominated deputies will count towards the meeting quorum if attendance has been agreed by the committee chair.
- 9.5. Members and staff from ICS partner organisations are expected to contribute to reasonable requests for information and input to the work undertaken by the committee.

10. Reporting

- 10.1. Papers will be made available five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback.
- 10.2. The committee will report on its activities to the ICB Board via minutes. In addition, an accompanying report will summarise key points of discussion, items recommended for decisions, the key activities undertaken or coordinated by the committee; any actions agreed to be implemented.
- 10.3. The committee will also provide reports as requested to other relevant ICS committees and/ or bodies (e.g., the Neighbourhood Based Care Board, the Acute Provider Collaborative, etc.)
- 10.4. The minutes of meetings shall be formally recorded and reported to the ICB Board for the purposes of assurance and made publicly available as part of ICB meeting papers.

11. Committee support

- 11.1. The committee will be supported by members of the ICB's governance team.
- 11.2. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

12. Monitoring adherence to the Terms of Reference

- 12.1. The co-chairs of the committee will be responsible for ensuring the committee abides by the terms of reference.

13. Review of Arrangements

- 13.1. The committee shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the committee considers this appropriate or necessary.
- 13.2. These terms of reference shall be reviewed by the committee chair and ICB chair on an annual basis, with changes proposed for approval to the ICB Board.